

IRO REVIEWER REPORT TEMPLATE -WC



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Date notice sent to all parties: May 7, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPT code 97033 Iontophoresis 15 min, 97035 Ultrasound 15 min, 97110 therapeutic exercise, 97140 manual therapy techniques, 97150 THER TX Grp 2/>in divs, G0283 E Stimulation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Texas Licensed, Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☐ Overturned (Disagree)

☒ Partially Overturned (Agree in part/Disagree in part): Overturn denial of CPT codes 97110 for therapeutic exercise, 97140 for manual therapy, and 97150 for therapeutic treatment. Uphold denial of CPT code 97033, CPT 97035 and CPT code G0283 including the iontophoresis, ultrasound and electrical stimulation respectively.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient has been well documented to be an individual who was noted to be attempting to restrain a xx. The patient was specifically noted to have had a right shoulder injury while working. The patient has been noted to have undergone 12 visits of physical therapy. The most recent records indicate that the patient's motion has been residually reduced far below normal. The records reveal that the abduction has been well documented

to be under 90 degrees in the most recent records. The other components of the range of motion have also been referenced. In particular, we have review of the provider records and notes of the treating physical therapist. Flexion has been noted to most recently be maximally 115 degrees again with abduction of under 90 degrees. There has been noted to be associated persistent pain in the affected right shoulder. The patient further has been noted to reveal that the denial letters have not supported an indication for any ongoing formal supervised therapy. An appeal regarding same has documented the persistent pain and subnormal motion. It should also be noted that the records reveal that this individual has a displaced torn rotator cuff on MRI with retraction and has been considered for surgical intervention.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Despite the fact that the patient is considered for surgical intervention and in spite of the 12 prior therapy visits, this individual clearly has a diagnosis compatible with adhesive capsulitis. The applicable ODG guidelines regarding the shoulder and specifically with regards to adhesive capsulitis, supports up to 16 visits specifically for that diagnosis. The patient would clearly have an improved prognosis with a resumption of therapy. It should be noted however that some of the CPT codes that have been considered for appeal are not supported by the guidelines applicable including physical therapy and ODG regarding the shoulder chapter, specifically the CPT code 97033, CPT 97035 and CPT code G0283 including the iontophoresis, ultrasound and electrical stimulation respectively would not be considered medically reasonable or necessary. However, CPT codes 97110 for therapeutic exercise, 97140 for manual therapy, and 97150 for therapeutic treatment would be considered medically reasonable and necessary in order to treat the adhesive capsulitis. The first ODG criterion is noted below and at this time, this reviewer's opinion is as discussed herein as per applicable clinical guidelines.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**